91-2079

No. _____

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, THE MARY LANNING MEMORIAL HOSPITAL ASSOCIATION, MEMORIAL COMMUNITY HOSPITAL, INC., MEMORIAL HOSPITAL OF DODGE COUNTY, MEMORIAL HOSPITAL AND ST. MARY'S HOSPITAL, PETITIONERS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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QUESTIONS PRESENTED FOR REVIEW

Under the Medicare statute for the years under appeal, hospitals were reimbursed for their "reasonable cost" of providing services to Medicare patients. The statute permits the use of "cost limits" based on estimates as one of the methods of determining reasonable cost.

The Medicare statute also provides that the Secretary must provide for "suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii) ("clause (ii)"). The Supreme Court in *Bowen v. Georgetown University Hospital,* 488 U.S. 204, 210 (1988), held that clause (ii) requires "case-by-case inquiry into the accuracy of reimbursement determinations for individual providers," and does not authorize retroactive rulemaking by the Secretary to change the methods of reimbursement.

The questions presented for review are:

1. Are the case-by-case adjustments required under clause (ii) limited to year-end book-balancing to reconcile interim payments received during the year with the amounts due under the regulatory methods for determining reasonable cost, as the Eighth and D.C. Circuits have held, or must they include substantive adjustments to an individual provider's reimbursement when the regulatory methods themselves result in inadequate or excessive reimbursement, as the Ninth Circuit has held.

A necessary subquestion is whether the Secretary's cost limit regulation at 42 C.F.R. § 413.30, which permits Medicare providers to obtain only narrow exceptions to the cost limits, is consistent with clause (ii) where it does not provide any mechanism for relief for providers which receive inadequate reimbursement due to an admitted flaw in the cost limits methodology.

2. Does *Georgetown's* prohibition against retroactive rulemaking extend to preclude relief to an individual provider under clause (ii) through the remedy granted to Medicare providers by Congress under 42 U.S.C. § 1395oo for case-by-case adjudications if the relief sought would have constituted retroactive rulemaking had the Secretary made the relief applicable to all providers through rulemaking.

RULE 29.1 LIST

The parent company of Good Samaritan Hospital is Good Samaritan Health Systems, Inc. The parent company of Memorial Community Hospital, Inc. is Memorial Community Health System, Inc. The parent company of St. Mary's Hospital is St. Elizabeth Health System.

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No. _____

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, THE MARY LANNING MEMORIAL HOSPITAL ASSOCIATION, MEMORIAL COMMUNITY HOSPITAL, INC., MEMORIAL HOSPITAL OF DODGE COUNTY, MEMORIAL HOSPITAL AND ST. MARY'S HOSPITAL, PETITIONERS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

The Petitioners, Good Samaritan Hospital, The Mary Lanning Memorial Hospital Association, Memorial Community Hospital, Inc., Memorial Hospital of Dodge County, Memorial Hospital and St. Mary's Hospital, respectfully pray that a Writ of Certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit, entered in the above proceeding on December 30, 1991.

OPINIONS BELOW

The opinion of the Court of Appeals for the Eighth Circuit is reported at 952 F.2d 1017 (8th Cir. 1991), and is reprinted in the Appendix at 1a. The Memorandum Deci-

sion of the United States District Court for the District of Nebraska (Urbom, D.J.) is reported at [1990 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 38,400 (D. Neb. Feb. 16, 1990), and is reprinted in the Appendix at 19a. The decisions of the Provider Reimbursement Review Board are reprinted in the Appendix beginning at 37a.

JURISDICTION

The final judgment of the United States Court of Appeals for the Eighth Circuit was issued and entered on December 30, 1991. The Petitioners filed a Petition for Rehearing and Suggestion for Rehearing En Banc on January 11, 1992. The Order denying both the Petition for Rehearing and Suggestion for Rehearing En Banc was entered on February 7, 1992. (Appendix at 18a.) On April 28, 1992 this Court granted the Petitioners' application for an extension of time to file the Petition for Certiorari until July 6, 1992.

The jurisdiction of this Court to review the judgment of the Eighth Circuit is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Petitioners assert that the Secretary of Health and Human Services ("Secretary") violated 42 U.S.C. § 1395x(v)(1)(A)(ii), the provision of the Medicare Act which directs the Secretary to make a suitable retroactive corrective adjustment to a Medicare provider when the Secretary's chosen methods of cost calculation result in inadequate reimbursement of an individual provider's reasonable cost. The text of 42 U.S.C. § 1395x(v)(1)(A) is reprinted in full in the Appendix at 72a.

STATEMENT OF THE CASE

The Petitioners are rural Nebraska hospitals which are providers of inpatient hospital services to Medicare beneficiaries, pursuant to "Provider Agreements" with the Secretary. For the cost reporting periods under appeal in this case, the Medicare statute required the Secretary to reimburse providers the lower of the "reasonable costs" of furnishing covered services to Medicare beneficiaries or the customary charge for such services. 42 U.S.C. § 1395f(b). "Reasonable cost" is defined as "the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A).

The Medicare statute directs the Secretary to establish a method or methods for calculating "reasonable costs." *Id.* However, the statute also provides that when the Secretary's methods result in reimbursement to an individual provider that "proves to be either inadequate or excessive" to reimburse that provider's actual reasonable cost, the Secretary is required to make a "suitable retroactive corrective adjustment" to the reimbursement for that provider. 42 U.S.C. § 1395x(v)(1)(A)(ii) (hereafter "clause (ii)".)

One of the methods of determining reasonable cost permitted by the statute is a schedule "of limits on the direct or indirect overall incurred costs or incurred cost of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services. . . ." *Id.* Pursuant to this statutory authority, the Secretary has published annual schedules of "cost limits." The legislative history accompanying the authority to establish the cost limits indicates that they were to be applied on a presumptive basis and that providers would have the right "to obtain relief from the effect of the cost limit on the basis of

evidence of the need for such an exemption." S. Rep. No. 92-1230, 92nd Cong., 2nd Sess. 187-189 (1972).

The Secretary's cost limit methodology for the years at issue here classified hospitals as urban (i.e., located in a Standard Metropolitan Statistical Area ("SMSA")) or rural (i.e., not in a SMSA), and used a wage index for the provider's geographic location to determine the labor-related component of a provider's costs. The data used to develop the wage index was from the Bureau of Labor Statistics ("BLS"). This BLS data did not distinguish between part-time and full-time employees. The result, admitted by the Secretary, is that the wage index was distorted downward for those areas that had a high proportion of part-time employees.

The Secretary has promulgated regulations under which providers may request a reclassification, exemption or exception from the cost limits. 42 C.F.R. § 405.460(d)-(f) (1975), *recodified as* 42 C.F.R. § 413.30(d)-(f) (1991). However, as the parties below agreed, none of these provisions permit any relief from the cost limits where providers exceed the cost limits due to the failure of the cost limits methodology to account for the use of part-time employees. The Secretary's position in this and other cases is that unless a provider's claim for relief qualifies as one of the exemptions or exceptions set forth in the regulation, no relief is available in the form of a retroactive corrective adjustment when the reimbursement proves to be inadequate.

Each of the Petitioners is classified as a rural Nebraska hospital for Medicare purposes. Hospitals in rural Nebraska as a whole, and each petitioner individually, employs a high percentage of part-time employees. As a result, each of the Petitioners exceeded the rural Nebraska Medicare cost limits in the years under appeal (FYs 1980-1983). Pursuant to 42 U.S.C. § 1395oo, each of the Petitioners filed an appeal to the Provider Reimbursement Review Board ("PRRB") for the years in which they exceeded the cost limits.

The Hospitals contended in their appeals that their costs in excess of the cost limits were nonetheless reasonable. They challenged the fact that the Medicare cost limits (1) did not account for the use of part-time employees, (2) did not permit rural hospitals to show they incurred similar costs as urban hospitals, and (3) were applied in a conclusive rather than a presumptive fashion, because there was no regulatory exceptions mechanism available by which the providers could obtain relief from the limits for these problems. They therefore claimed they were entitled to a retroactive corrective adjustment under clause (ii). In addition, Petitioner Memorial Community Hospital also challenged the Secretary's denial of its request for reclassification from "rural" hospital status to "urban" hospital status.

The Board granted jurisdiction over the appeals of the six hospitals, for a total of twenty cost years. Because the Board is bound by the Secretary's regulations, including the cost limits methodology, it could not grant the Hospitals the relief they sought, i.e., reimbursement in excess of the cost limits. The Board therefore granted the Hospitals' request for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1), thereby allowing the hospitals to take their challenge directly into district court. (Appendix 37a-53a). The PRRB denied jurisdiction over the appeals of three of the cost years.[1]

On cross-motions for summary judgment, the district court ruled in favor of the Hospitals in that it held that the cost limits may be applied only on a presumptive rather than a conclusive basis. The court held that clause (ii) of § 1395x(v)(1)(A) required the Secretary to make retroactive

[1] The Board denied jurisdiction over St. Mary's Hospital for FY 1981, Memorial Hospital (Seward) for FY 1981 and Memorial Hospital of Dodge County for FY 1980 on the ground that the appeals for those years were not timely filed.

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adjustments to the Hospitals' reimbursement where the Secretary's cost limits method, even though valid, resulted in inadequate reimbursement of the Hospitals' reasonable costs. In so holding, the court relied on the prior decision of the Eighth Circuit in *St. Paul-Ramsey Medical Center v. Bowen,* 816 F.2d 417 (8th Cir. 1987). The district court rejected the Secretary's contention that *St. Paul-Ramsey* was no longer good law after the Supreme Court's decision in *Bowen v. Georgetown University Hospital,* 488 U.S. 204 (1988) ("*Georgetown*"). Rather, the district court held that *St. Paul-Ramsey* was consistent with the *Georgetown* decision, which held that clause (ii) does not authorize retroactive rulemaking, but does require case-by-case adjustments for individual providers where the regulatory methods do not result in correct reimbursement.

The district court remanded the case to the Secretary "for a hearing from which he (1) shall apply to the cost years under appeal a wage index which takes into account the high use of part-time employees by hospitals in Nebraska and (2) shall consider the non-MSA designation of the plaintiffs in determining whether the aggregate reimbursement produced by the methods of determining costs has proved to be inadequate." With respect to Memorial Community Hospital, the district court held the Secretary's denial of its reclassification request was not arbitrary and capricious. The district court also affirmed the decision of the PRRB denying jurisdiction over three of the cost years.

The court of appeals reversed the district court's ruling that the hospitals were entitled to a suitable retroactive corrective adjustment where the cost limits regulation resulted in inadequate reimbursement, and held that its prior interpretation of clause (ii) in *St. Paul-Ramsey* had been overruled by the Supreme Court's decision in *Georgetown.* The Eighth Circuit read *Georgetown* as holding that the retroactive corrective adjustment required by clause (ii) is only

year-end "book-balancing" to reconcile the interim estimated payments a provider receives during the year with the amounts actually due for the year pursuant to the Secretary's methods of determining reasonable cost. It concluded that the kind of retroactive corrective adjustment sought by the Hospitals, which would reimburse costs in excess of the cost limits, would amount to retroactive rulemaking that *Georgetown* prohibited.

The court of appeals further held that the Secretary's cost limit methodology was valid and reasonable. Although the BLS data used for the wage index did not account for part-time employees, the court deferred to the Secretary's conclusion that it was the best data available. The court of appeals also affirmed the district court's ruling with respect to the reclassification of Memorial Community Hospital and PRRB jurisdiction over three of the years under appeal.[2]

REASONS FOR GRANTING THE WRIT

I. THE COURTS OF APPEALS DISAGREE AS TO THE PROPER INTERPRETATION OF THE SUITABLE RETROACTIVE CORRECTIVE ADJUSTMENT PROVISION IN CLAUSE (ii) AND THIS COURT'S DECISION IN *GEORGETOWN*

Prior to this Court's decision in *Georgetown,* the Eighth Circuit in *St. Paul-Ramsey* held that under clause (ii) the Secretary has a duty to make a suitable retroactive corrective adjustment to a provider's reimbursement whenever his methods of determining reasonable cost result in inadequate or excessive reimbursement. Other courts of appeals had similarly held that under clause (ii) the Secretary is required to make a retroactive adjustment when a provider receives

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[2] The Petitioners do not seek certiorari on the issues of the reclassification of Memorial Community Hospital and PRRB jurisdiction over the three cost years.

reimbursement that is less or greater than its actual, reasonable cost, as calculated under the cost limits or any other method for determining reasonable cost. *See Medical Center Hosp. v. Bowen,* 839 F.2d 1504 (11th Cir. 1988); *Regents of the Univ. of Cal. v. Heckler,* 771 F.2d 1182 (9th Cir. 1985); *Springdale Convalescent Center v. Mathews,* 545 F.2d 943 (5th Cir. 1977); *Whitecliff, Inc. v. United States,* 536 F.2d 347 (Ct. Cl. 1976), *cert. denied,* 430 U.S. 969 (1977); *Kingsbrook Jewish Medical Center v. Richardson,* 486 F.2d 663 (2d Cir. 1973). Only one court had held that clause (ii) is limited to year-end book-balancing. *Daughters of Miriam Center for the Aged v. Mathews,* 590 F.2d 1250 (3d Cir. 1978).

In *Georgetown,* the Secretary argued that clause (ii) authorized him to engage in across-the-board retroactive rulemaking applicable to all providers. This Court unanimously rejected the Secretary's interpretation, holding that clause (ii) authorized only individual case-by-case adjustments, not retroactive rulemaking. "To the contrary, we agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases." 488 U.S. at 209. In declining to defer to the Secretary's interpretation that clause (ii) authorized retroactive rulemaking, the Court in *dicta* noted that in the past the Secretary had asserted that clause (ii) required only year-end book-balancing. 488 U.S. at 211 and n.2.[3]

[3] However, the Secretary has cited clause (ii) as authority for numerous other actions apart from year-end book-balancing or retroactive rulemaking. *See, e.g., Medical Center Hospital,* 839 F.2d at 1511 (Secretary argued clause (ii) is satisfied by cost limits exceptions process in 42 C.F.R. § 413.30); *Springdale Convalescent Center,* 545 F.2d at 954 (Secretary argued clause (ii) authorized regulation at 42 C.F.R. § 413.134(d)(3) (formerly § 405.415(d)(3)), which permits Medicare to recoup the difference between accelerated and straight-line depreciation for all years of participation in the Medicare program when a provider leaves the program); *St. James Hospital v. Heckler,* 760 F.2d 1460 (7th Cir. 1985), *cert. denied,* 474 U.S. 902 (1985) (Reply Brief for Appellant at 22-23) (Secretary argued that clause (ii) authorized the regulation at 42 C.F.R. § 405.1885 governing reopening of cost reports for prior periods).

Subsequent to the *Georgetown* decision, the D.C. Circuit in *Hennepin County v. Sullivan,* 883 F.2d 85 (D.C. Cir. 1989), *cert. denied,* 493 U.S. 1043 (1990), interpreted the *Georgetown* Court's observation regarding the Secretary's past position as a holding that clause (ii) only permits the Secretary to perform year-end book-balancing to adjust a provider's interim reimbursement with the amounts actually due under the regulations. The Eighth Circuit in the decision below similarly held that, according to *Georgetown,* clause (ii) only requires book-balancing.[4]

In contrast, the Ninth Circuit expressly rejected this interpretation of *Georgetown* in *Mt. Diablo Hospital v. Sullivan,* 5 Medicare and Medicaid Guide (CCH) ¶ 40,203 (9th Cir. April 28, 1992), *pet. for reh'g with a suggestion for reh'g in banc filed* June 11, 1992, a case which also involves a challenge to the cost limits for failure to account for part-time employees. (A copy of the Ninth Circuit decision is contained in the Appendix at 55a.) Instead, the Ninth Circuit held that *Georgetown* did not overrule its earlier decision in *Regents of the Univ. of California v. Heckler,*

[4] In *Sierra Medical Center v. Sullivan,* 902 F.2d 388 (5th Cir. 1990), the provider sought to have a change in a regulation applied retroactively to a prior cost year. The Fifth Circuit rejected the provider's argument, relying on *Georgetown's* prohibition on retroactive rulemaking. It is unclear whether the Fifth Circuit concluded that *Georgetown* overruled its prior decision in *Springdale Convalescent Center v. Mathews,* 545 F.2d 943 (5th Circuit 1977).

771 F.2d 1182 (9th Cir. 1985), which interpreted clause (ii) to require the Secretary to make a retroactive adjustment to reimburse a provider for all its "reasonable costs," even if those costs exceeded the cost limits and did not qualify for treatment as an exception or exemption under the Secretary's regulations.

The Ninth Circuit expressly disagreed with the conclusion of the Eighth Circuit, in *Good Samaritan,* that the kind of individual adjustment the hospitals were seeking amounted to a retroactive change in the cost limit methodology in violation of *Georgetown* and its prohibition on retroactive rulemaking. (Appendix at 70a.) The Ninth Circuit held, instead, that the hospitals were seeking only the very kind of case-by-case adjustment to their individual reimbursement that was sanctioned by this Court in *Georgetown.* The Ninth Circuit remanded the case to permit Mt. Diablo Hospital to demonstrate that its costs in excess of the cost limits were reasonable.

Thus, there is a clear and direct split among the Circuits concerning the duty imposed on the Secretary by clause (ii) and the proper interpretation of this Court's decision in *Georgetown.* In the Ninth Circuit, as well as in the Second and Eleventh Circuits and the Claims Court, clause (ii) continues to be interpreted to require substantive reimbursement adjustments to individual providers, not simply year-end book-balancing. In the Eighth and D.C. Circuits, the duty imposed by clause (ii) is limited to accounting reconciliations at the end of the year. The granting of this petition therefore is necessary to achieve uniform construction of the statutory language, to assist the Secretary in the administration of the Medicare program, and to ensure that all Medicare providers will understand what the statute means.

II. THE EIGHTH CIRCUIT'S INTERPRETATION OF CLAUSE (ii) TO DENY PETITIONERS A REMEDY FOR AN INDIVIDUAL ADJUSTMENT TO THEIR REIMBURSEMENT UNDER 42 U.S.C. § 1395oo IS IN CONFLICT WITH *GEORGETOWN.*

The Petitioners sought an individual adjustment to their reimbursement because the cost limits methodology was applied to them in a conclusive fashion, rather than in a presumptive manner, which resulted in inadequate reimbursement of their reasonable costs. The Eighth Circuit found that the Petitioners' claim amounted to retroactive rulemaking because, if the Petitioners succeeded in obtaining any reimbursement in excess of the cost limits methodology, the remedy would be tantamount to a retroactive change in the cost limits rules, which the court found was prohibited by *Georgetown.*

The Eighth Circuit's characterization of the remedy Petitioners' seek as retroactive rulemaking ignores the very dichotomy recognized in *Georgetown* between case-by-case adjudications resulting in adjustments to individual providers' reimbursement, which by nature are retroactive, and across-the-board rulemaking by the Secretary, which must be prospective. The only way the Hospitals can obtain the adjustments they seek to their reimbursement is through the appeals process in 42 U.S.C. § 1395oo, which requires that the appeals be brought on a retrospective basis following the close of the cost year under appeal. Certainly nothing in the *Georgetown* construction of clause (ii) even intimated that it intended to overrule the remedy given in § 1395oo(f), i.e., to permit providers to go to court to challenge the conclusive application of the cost limits and to obtain an individualized adjustment for reimbursement in excess of the cost limits. This is especially so since the authority to promulgate the cost limits was contained in the same legislation that created the remedy in § 1395oo. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 223,243(a).

III. THIS ISSUE INVOLVES THE REQUISITE PUBLIC IMPORTANCE TO MEDICARE PROVIDERS THROUGHOUT THE NATION

The interpretation of clause (ii) affects numerous Medicare providers throughout the country that are reimbursed on the basis of "reasonable cost." While, with the advent of the prospective payment system (PPS) beginning October 1, 1983, acute care hospitals are no longer reimbursed on the basis of reasonable cost, the Medicare cost limits remain applicable to skilled nursing facilities ("SNFs") and home health agencies ("HHAs"). Presently, there are 6,200 participating SNFs and 6,000 HHAs that are subject to the Secretary's cost limits. For those providers that exceed the cost limits and do not fall within one of the very narrow exceptions to the limits provided for by the Secretary, this issue remains of paramount importance.

CONCLUSION

For the foregoing reasons, this Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

Nos. 90-1641/1642

GOOD SAMARITAN HOSPITAL, ETC., ET AL., APPELLANTS,

v.

LOUIS W. SULLIVAN, ETC., APPELLEE.

Appeals from the United States District Court for the District of Nebraska

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Submitted: December 12, 1990
Filed: December 30, 1991

Before MCMILLIAN and FAGG, Circuit Judges, and ARNOLD,* District Judge.

McMILLIAN, Circuit Judge.

Good Samaritan Hospital, Memorial Community Hospital, Memorial Hospital (Seward), Memorial Hospital of Dodge County, St. Mary's Hospital, and Mary Lanning Memorial Hospital (collectively appellants[1]) appeal from a

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* The Honorable Morris S. Arnold, United States District Judge for the Western District of Arkansas, sitting by designation.

[1] Mary Lanning Memorial Hospital is not a party appellant in this case because we hold that we lack appellate jurisdiction over it as discussed below. Mary Lanning Memorial Hospital was a plaintiff below and remains a cross-appellee here.

final order entered in the District Court for the District of Nebraska. *Good Samaritan Hospital v. Sullivan,* No. CV88-L-523 (D. Neb. Feb. 16, 1990) (order and memorandum). The Secretary of Health and Human Services (Secretary) cross-appeals from this final order. In the district court, both sides agreed that summary judgment was appropriate because the facts were not in dispute, and the district court granted partial summary judgment in favor of each side. For reversal, appellants argue that (1) the Secretary's refusal to reclassify Memorial Community Hospital as an urban hospital is arbitrary and capricious, (2) the Provider Reimbursement Review Board improperly denied jurisdiction over three cost years, and (3) the district court erred in granting relief that it did. For reversal, the Secretary argues that (1) this court lacks jurisdiction over Mary Lanning Memorial Hospital[2] and (2) the district court erred in allowing appellants a retroactive change in the prescribed methods of Medicare reimbursement. For the reasons discussed below, we affirm in part and reverse in part.

I. BACKGROUND FACTS

A. *Medicare Reimbursement Structure*

Under Part A of Medicare, health care providers, in this case hospitals, are reimbursed for providing medical services to Medicare patients. *See* Title XVIII of the Social Security Act, *as amended,* 42 U.S.C. § 1395 *et seq.* (the Medicare Act). Hospitals participate as "providers of services" by entering into an agreement with the Secretary.

[2] The Secretary originally argued that we also lack jurisdiction over Memorial Community Hospital, Memorial Hospital (Seward), Memorial Hospital of Dodge County and St. Mary's Hospital, but the government changed its position in its reply brief.

Id. § 1395x(u). Providers are reimbursed for the lesser of "reasonable costs" or the "customary charges" for services furnished to Medicare beneficiaries. *Id.* § 1395f(b)(1). "Reasonable cost" is defined as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." *Id.* § 1395x(v)(1)(A).[3] Reasonable cost is determined in accordance with regulations promulgated by the Secretary and these regulations

> may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, [and] may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services.

Id. In addition, the Medicare Act requires the Secretary to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." *Id.* § 1395x(v)(1)(A)(ii) (clause (ii)).

In 1972, Congress authorized the Secretary to promulgate regulations which establish limits on the costs to be recognized as reasonable. Pub. L. No. 92-603, 86 Stat. 1329 (1972). Pursuant to this statutory authority, the Secretary first promulgated regulations establishing limits on hospital inpatient general routine care in 1974. 20 C.F.R. § 405.460

[3] After October 1, 1983, providers are reimbursed under the Medicare Prospective Payment System (PPS). *See* 42 U.S.C. § 1395ww(d). This case involves pre-1983 cost years and thus PPS is inapplicable.

(1975), *redesignated as* 42 C.F.R. § 413.30 (1990). These regulations establish specific cost limits based on factors including type of services furnished, geographical location, institutional size, nature and mix of services furnished, and type and mix of patients treated. 42 C.F.R. § 413.30(b) (1990). Providers can request an exemption or exception under specific statutory criteria and procedures. *See id.* § 413.30(e), (f) (1990).[4] These cost schedules are updated yearly. Initially, these cost schedules categorized hospitals by (1) whether they were located in a Standard Metropolitan Statistical Area (SMSA), (2) the per capita income of the location area and (3) bed size. SMSAs are used to distinguish urban and rural hospitals. Those hospitals located within a SMSA are considered urban and thus receive a higher per capita limit than rural hospitals (those located outside of SMSAs). *See* 44 Fed. Reg. 31,806 (1979). Changes to SMSA designations, based upon later census data, are applied solely to fiscal years following the effective date of the change.

In 1979, the Secretary promulgated new regulations to change one part of the cost limits. Rather than using area per capita income to adjust for variations in wage levels, a wage index was developed. *Id.* To determine the wage index, the Bureau of Labor Statistics of the Department of Labor divided the total hospital wages paid in one year by the total number of hospital workers to arrive at an average monthly hospital wage. This data did not take into account the number of full or part-time workers at any given hospital until 1984 when Congress required the Secretary to conduct a study to develop a wage index that would adjust for part-time workers. A new wage index was applied prospectively effective May 1, 1986. Pub. L. No. 99-272, § 9103(a), 100 Stat. 156 (1986).

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[4] Both appellants and the Secretary agree that none of these regulatory exceptions or exemptions is applicable in the present case.

In order to receive reimbursement, a provider is required to file an annual cost report with a fiscal intermediary (such as Blue Cross). 42 C.F.R. § 413.20 (1990). The fiscal intermediary reviews the cost report, determines the amount of reimbursement due the provider, and issues a "notice of program reimbursement" (NPR). *Id.* If the provider is dissatisfied with the NPR, the provider can file, within 180 days of receiving the NPR, a request for a hearing before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. § 1395oo(a). A PRRB decision that it lacks the authority to decide a question of law is considered a final agency decision and the provider may, within 60 days, seek judicial review. *Id.* § 1395oo(f)(1).

B. Facts in the Present Case

Appellants are rural Nebraska hospitals who exceeded the Secretary's promulgated cost limits in the early 1980s and filed appeals to the PRRB challenging the NPRs for the following cost years: Good Samaritan Hospital, 1981, 1982, 1983; Memorial Community Hospital, 1980, 1981, 1982, 1983; Memorial Hospital (Seward), 1980, 1982, 1983; Memorial Hospital of Dodge County, 1981, 1982, 1983, 1984; St. Mary's Hospital, 1980, 1982, 1983; and Mary Lanning Memorial Hospital, 1981, 1982, 1983. Additionally, three hospitals, which were parties to a prior group appeal, neglected to raise any issues concerning certain cost years, and therefore, the PRRB denied jurisdiction over the following cost years: Memorial Hospital (Seward), 1981; Memorial Hospital of Dodge County, 1980; and St. Mary's Hospital, 1981. Appellants challenged the fact that Medicare cost limits (1) did not account for the use of a high percentage of part-time employees, (2) did not permit rural hospitals to show they incurred the same costs as urban hospitals, and (3) were applied in a conclusive rather than a pre-

sumptive fashion. Memorial Community Hospital also challenged the denial of its request to be reclassified as an urban hospital.

Appellants claim that the wage-index regulations, by not accounting for part-time workers, disadvantage hospitals which employ a greater percentage of part-time workers than the average hospital. A hospital with a greater percentage of part-time workers will have a lower average monthly hospital wage. Because average monthly hospital wage is one factor used to determine the per diem limit for a given region, hospitals in that area will be disadvantaged. Appellants allege that rural Nebraska hospitals hire a greater percentage of part-time workers than the national average and thus they are disadvantaged by the Secretary's system. A study commissioned by appellants showed that an 11.04 percent adjustment factor applied to the wage index would correct for the failure to account for part-time employees. Following the Secretary's 1984 study of the disparity created by not distinguishing between full and part-time employees, the revised wage index (which went into effect in 1986) increased the rural Nebraska wage index by 11.25 percent. 50 Fed. Reg. 24,403 (1985). Appellants allege that a corrective factor should be applied to the cost years in question to correct for the disadvantage suffered by them prior to 1986.

As to the distinction between rural and urban hospitals, appellants allege that they are located so close to metropolitan areas that their wages were comparable to the wages of urban hospitals. Appellants allege that the classification of urban and rural hospitals is arbitrary and capricious. Appellants argue that they should be allowed to present evidence to show that they pay comparable wages and then should be reclassified as urban hospitals for the years in question.

The PRRB granted appellants' request for expedited judicial review, allowing appellants to take their challenge directly into district court. The district court, on cross-motions for summary judgment, ruled in favor of appellants insofar as it held that the cost limits may be applied only on a presumptive rather than a conclusive basis. The district court found that the Secretary had a statutory duty to make corrective adjustments under *St. Paul-Ramsey Medical Center v. Bowen,* 816 F.2d 417 (8th Cir. 1987) (*St. Paul-Ramsey*). In doing so, the district court further ruled that *Bowen v. Georgetown University Hospital,* 488 U.S. 204 (1988) (*Georgetown*), did not overrule, and was in fact consistent with, *St. Paul-Ramsey*. The district court remanded the case to the Secretary to determine under clause (ii) whether appellants are entitled to reimbursement of reasonable costs beyond the amount already determined as reasonable under the cost schedule. The district court upheld the Secretary's refusal to reclassify Memorial Community Hospital as an urban hospital for the years 1980 to 1983 and the PRRB's denial of jurisdiction over the single-year cost limit challenges of Memorial Hospital (Seward), Memorial Hospital of Dodge County and St. Mary's Hospital.

Appellants then appealed to this court claiming error in the district court's (1) refusal to reclassify Memorial Community Hospital, (2) denial of jurisdiction with respect to single-cost years, and (3) remedy. The Secretary cross-appealed claiming (1) Mary Lanning Memorial Hospital lacked jurisdiction to appeal and (2) the district court erred in finding that the Secretary's methods of provider reimbursement are presumptive only and that appellants are entitled to relief under clause (ii).

II. JURISDICTION

There is a threshold issue of jurisdiction as to Memorial Community Hospital (Seward), Memorial Hospital of Dodge County, St. Mary's Hospital, and Mary Lanning Memorial Hospital because they were not named in the Notice of Appeal which stated in part that "[n]otice is hereby given that Plaintiffs, Good Samaritan Hospital, et al., hereby appeal." Rule 3(c) of the Federal Rules of Appellate Procedure as construed in *Torres v. Oakland Scavenger Co.*, 487 U.S. 312 (1988) (*Torres*), requires that each party be named in the notice of appeal and the use of "et al." is insufficient notice of appeal. *Id.* at 318; *see Wise v. Parkman*, 932 F.2d 745 (8th Cir. 1991); *United States v. Schneider*, 926 F.2d 777 (8th Cir. 1991) (*Schneider*); *Goos v. ICC*, 911 F.2d 1283 (8th Cir. 1990). Therefore, the use of "et al." in the notice of appeal does not give this court jurisdiction over any of the hospitals except Good Samaritan Hospital.

In spite of the strict jurisdictional rule established in *Torres*, we hold that we have jurisdiction over Memorial Community Hospital, Memorial Hospital (Seward), Memorial Hospital of Dodge County, and St. Mary's Hospital, but dismiss the appeal of Mary Lanning Memorial Hospital for lack of jurisdiction. The *Torres* Court recognized that "if a litigant files papers in a fashion that is technically at variance with the letter of a procedural rule, a court may nonetheless find that the litigant has complied with the rule if the litigant's action is the functional equivalent of what the rule requires." 487 U.S. at 316-17 (citation omitted). In the present case, appellants filed an Appeal Information Form at the same time as their notice of appeal (thus within the sixty days for appeal). In this Appeal Information Form, appellants set forth their issues on appeal (emphasis added):

> Whether the District Court erred in determining that the Defendant's refusal to reclassify *Memorial Community Hospital* as an urban hospital for the period prior to June 1983, was not arbitrary and capricious.
>
> Whether the District Court erred in dismissing the claims of *St. Mary's Hospital* for fiscal year 1981, *Memorial Hospital (Seward)* for fiscal year 1981, and *Memorial Hospital of Dodge County* for fiscal year 1980.

Therefore, the issue in this case becomes whether this Appeal Information Form is "a functional equivalent of what the rule requires." We hold that it is. The Appeal Information Form was filed within the time required for the notice of appeal and provided the Secretary with clear notice that the four hospitals listed are appealing the district court's order. While this is a case of first impression in this circuit, we agree with other circuits which have held that additional documents filed within the statutory period for notices of appeal are the functional equivalent of a notice of appeal and, therefore, serve as a notice of appeal. The Third Circuit in *Dura Systems, Inc. v. Rothbury Inv., Ltd.*, 886 F.2d 551, 555 (3d Cir. 1989), *cert. denied*, 493 U.S. 1046 (1990), held that a Consent Order could serve as the functional equivalent of what Rule 3(c) required when filed within the time for filing an appeal under Fed. R. App. R. [*sic*] 4. *Accord Warfield v. Fidelity & Deposit Co.*, 904 F.2d 322 (5th Cir. 1990). The Fifth Circuit explained that the defect in the notice of appeal of not specifically naming the parties appealing can be cured "by filing a supporting memorandum or some other paper which contains the name of each appellant." *Id.* at 325 (citations omitted).[5] Moreover, this

[5] The Seventh Circuit takes a different approach and does not adopt this collateral document rule and thus requires that each party be named in the notice of appeal. *Allen Archery, Inc. v. Precision Shooting Equip., Inc.*, 857 F.2d 1176 (7th Cir. 1988) (per curiam). We decline to adopt the approach of the Seventh Circuit.

approach is consistent with Eighth Circuit precedent. In *Schneider,* this court found a lack of jurisdiction because "the 'certificate of interested persons' [which listed each appellant not named on the notice of appeal] was submitted after the appeal time had expired." 926 F.2d at 778.

We hold that when the collateral document naming the specific parties is filed within the appeal time, jurisdiction exists over those parties. We therefore hold that we have jurisdiction over Good Samaritan Hospital as well as Memorial Community Hospital, Memorial Hospital (Seward), Memorial Hospital of Dodge County, and St. Mary's Hospital. The appeal of Mary Lanning Memorial Hospital is dismissed for lack of jurisdiction.

III. ISSUES ON THE MERITS

We review the district court's grant of summary judgment de novo. We thus apply the same standard of review as the district court, that is, whether the Secretary's actions are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *Hennepin County v. Sullivan,* 883 F.2d 85, 91 (D.C. Cir. 1989) (*Hennepin County*), *cert. denied,* 493 U.S. 1043 (1990).

A. Scope of Secretary's Duty under clause (ii)

Appellants insist that the Medicare cost limits for the cost years in question did not reimburse their reasonable costs as required under 42 U.S.C. § 1395x(v)(1)(A). Appellants urge this court to affirm the district court's findings that the cost limits are to be applied presumptively and that providers are entitled under *St. Paul-Ramsey* to suitable retroactive corrective adjustments where the cost limits methodology fails to reimburse their actual reasonable costs. On cross-appeal, the Secretary argues that the district court erred in relying on *St. Paul-Ramsey* because that decision

has been overruled by the Supreme Court in *Georgetown.* The Secretary claims that clause (ii) only authorizes year-end book-balancing, not retroactive modifications to the cost limits rules.

Because the district court remanded the claims of all six hospitals to the Secretary for further proceedings to determine if they were entitled to additional reimbursement for reasonable costs, Mary Lanning Memorial Hospital remains a cross-appellee for the limited purposes of this issue. We will continue to use the term "appellants" for the cross-appellees, but Mary Lanning Memorial Hospital is included only for the limited purposes of the clause (ii) analysis.

Clause (ii) requires that regulations "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii). We interpreted this statute in *St. Paul-Ramsey* and concluded that cost limits were only presumptive and "that § 1395x(v)(1)(A) imposes a statutory duty upon the Secretary *whenever* the chosen method of cost calculation fails to adequately reimburse all reasonable costs." 816 F.2d at 420 (citations omitted) (emphasis in original).

Our interpretation of clause (ii) in *St. Paul-Ramsey* was overruled by the Supreme Court in *Georgetown. Georgetown* presented the question "whether the Secretary may exercise this rulemaking authority to promulgate cost limits that are retroactive." 488 U.S. at 206. In 1983, the Secretary's 1981 wage-index rule was struck down for violating the notice and comment provisions of the Administrative Procedure Act. *Id.* After following the proper procedures, the Secretary enacted the wage-index rule in 1984 but tried to apply it retroactively to 1981. The Supreme Court held

that clause (ii) does not provide the "authority for the retroactive promulgation of cost-limit rules." *Id.* at 209. The Court explained that

> clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases. The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudiciation, not to rulemaking.

Id. (footnote omitted). The Court drew a distinction between clause (i) of § 1395x(v)(1)(A) which speaks of "providers" and clause (ii) which uses the term "a provider." "The distinction suggests that clause (ii), rather than permitting modifications to the cost-method rules in their general formulation, is intended to authorize case-by-case inquiry into the accuracy of reimbursement determinations for individual providers." *Id.* at 210. Finally, the Court concluded that clause (ii) does not permit changes in the methods used to reimburse costs, but only corrective adjustments to the aggregate amounts.

> [C]lause (ii) speaks in terms of adjusting the aggregate reimbursement amount computed by one of the methods of determining costs. . . . [N]othing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods.

Id. at 211 (emphasis in original). Therefore, clause (ii) merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year. *See id.* at 213 (citations omitted).

Appellants claim that they are not requesting a change in the method of calculating reimbursement, but merely want their aggregate reimbursements adjusted because the flaws in the existing methodology caused underreimbursement of their reasonable costs. Appellants claim that this does not amount to change of methodology or a retroactive change in the cost limit regulations as forbidden by *Georgetown*.

We disagree. Appellants are asking for retroactive rule changes, not merely the year-end book balancing allowed in *Georgetown*. Appellants do not claim that the Secretary inaccurately applied the cost methodology in place during the cost years in question. Instead, appellants want the methodology changed to correct what they believe are inequalities in the system. While they claim this is merely case-by-case analysis, it is not. Appellants are asking this court to order the Secretary to retroactively adjust cost limits for the number of part-time workers. Such relief would amount to a retroactive change in the *methods* used to compute costs that, after *Georgetown,* is invalid. Clause (ii) does not allow this court to reevaluate the appropriateness of the cost limit regulations, but only to reevaluate the calculations made pursuant to those regulations. *See Hennepin County,* 883 F.2d at 93.

The D.C. Circuit faced a similar situation in *Hennepin County* where a hospital sought additional reimbursement for medical education expenses. The hospitals claimed that because of its large medical education program, its expenses exceeded those of other hospitals and cited *St. Paul-Ramsey* in support. *Id.* at 90. The court rejected the argument of hospitals and noted "that *St. Paul-Ramsey* violated the rule against retroactive rulemaking." *Id.* The court explained that the hospital had received all that it was entitled to under the existing methodology, and that "[s]ection 1395x(v)(1)(A)(ii) is not a vehicle through which Medicare

providers may get a 'second bite at the apple.' " *Id.* at 92. *Accord Sierra Medical Center v. Sullivan,* 902 F.2d 388 (5th Cir. 1990). Appellants here are asking this court for a second bite at the apple because they feel cheated by the cost limit regulations. Clause (ii) does not allow such a result.

B. Cost Limit Rules' Validity

All appellants, during the years in question, were located outside of designated SMSAs and were thus classified as rural hospitals for the purposes of determining cost limits. They received a lower cost limit than hospitals within SMSAs and appellants claim they must compete with urban hospitals for staff. Appellants argue that the cost limit regulations are arbitrary and capricious because they fail to account for the use of part-time employees and use the SMSA designations as the sole means by which a hospital can be designated as an urban hospital. Appellants allege that the percentage of part-time employees in rural Nebraska hospitals was 44 percent while the national average was only 26 percent. Appellants claim that the Secretary knew of this inherent distortion in the wage index methodology, but did nothing to correct it until Congress forced the Secretary to do so in 1984. *See* Pub. L. No. 98-369, § 2316(a), 98 Stat. 1081 (1984).

We disagree with appellants and find the cost limit rules reasonable and valid. Simply because the Secretary later altered the wage index to account for part-time employees does not mean that the limits prior to the change are invalid. *See City of Austin v. Heckler,* 753 F.2d 1307, 1315 (5th Cir. 1985). To so hold would simply discourage the Secretary from changing and improving the regulations. At the time the regulations were in place, the Secretary claims that they were based upon the latest available data. *See* 44 Fed. Reg. 31,807 (1979). There is nothing arbitrary or

capricious about the cost limit methodology used by the Secretary. Both the wage index and the rural/urban distinction were based on objective data and regulations, and we hold the SMSA-based cost limit regulations are not arbitrary or capricious.

C. Classification of Memorial Community Hospital

Appellant Memorial Community Hospital (MCH) appeals the district court's affirmance of the Secretary's denial to reclassify it as an urban hospital for the years 1980 to 1983. Data from the 1980 census shows MCH located within the Omaha SMSA, but MCH's reclassification as an urban hospital was not effective until June 30, 1983. Therefore, MCH argues that because the census data shows that it had been operating as an urban hospital at least since 1980, it was arbitrary and capricious for the Secretary to deny the retroactive reclassification. We agree with the district court that to reclassify MCH as an urban hospital would violate the prohibition against across-the-board retroactive modifications in *Georgetown.* We therefore affirm the district court on this issue.

MCH argues that reclassification is required so that it is reimbursed for its reasonable costs. Additionally, MCH alleges this is not retroactive rulemaking because it is only requesting a case-by-case adjustment to its aggregate reimbursement, not an across-the-board change.[6] MCH is

[6] All of the cases on which Memorial Community Hospital relies are pre-*Georgetown* cases. Beyond that distinction, the two main cases deal with initial SMSA determinations and the use of different criteria in different parts of the county. *Addison Gilbert Hosp. v. Blue Cross Assoc./Blue Cross of Mass.*, Medicare & Medicaid Guide (CCH) ¶30,783 (HCFA Nov. 10, 1980); *Anna Jacques Hosp. v. Blue Cross Assoc./Blue Cross of Mass.*, Medicare & Medicaid Guide (CCH) ¶30,025 (PRRB July 16, 1979), *aff'd,* Medicare & Medicaid Guide (CCH) ¶30,781 (HCFA Sept. 14, 1979). The analysis of these cases, therefore, does not apply to reclassification based on new data and the retroactive application of that reclassification.

mischaracterizing its request. MCH is asking this court to engage in retroactive rulemaking. If the Secretary had to reclassify MCH based on the 1980 census data, then the Secretary would also have to retroactively reclassify all hospitals which changed SMSA classification as a result of the 1980 census data. This would amount to retroactive rulemaking which is forbidden under *Georgetown*.

D. PRRB Denial of Jurisdiction

The PRRB denied jurisdiction over the appeals of Memorial Hospital (Seward) for fiscal year 1981, Memorial Hospital of Dodge County for fiscal year 1980, and St. Mary's Hospital for fiscal year 1981 on the ground that the cost limit appeals were not filed within 180 days of the NPR as required by 42 U.S.C. § 1395oo(a)(3). The district court affirmed the decision of the PRRB. These three appellants seek to raise claims identical to those raised in the other cost years appealed. Therefore, because we denied relief for the cost years properly appealed, we need not reach this jurisdictional issue. Even if jurisdiction existed, the underlying claims would be denied.

E. Remedy

Appellants also challenge the relief granted by the district court. Appellants argue that the district court should have ordered the Secretary to apply an 11.25 percent adjustment factor to account for the disparity in part-time workers instead of just remanding the case for a determination of the appropriate reimbursement. Because we have decided that appellants are entitled to no relief, this issue is moot.

IV. CONCLUSION

Accordingly, we dismiss the appeal of Mary Lanning Memorial Hospital for lack of jurisdiction. We reverse the district court's grant of summary judgment in favor of appellants and hold that appellants are entitled to no corrective adjustment. We affirm the district court's grant of summary judgment in favor of the Secretary (1) denying MCH retroactive reclassification as an urban hospital and (2) denying jurisdiction to Memorial Hospital (Seward) for fiscal year 1981, Memorial Hospital of Dodge County for fiscal year 1980, and St. Mary's Hospital for fiscal year 1981.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 90-1641NEL

GOOD SAMARITAN HOSPITAL, ETC., ET AL., APPELLANTS,

v.

LOUIS W. SULLIVAN, ETC., APPELLEE.

Order Denying Petition for Rehearing and
Suggestion for Rehearing En Banc

The suggestion for rehearing en banc is denied. The petition for rehearing is also denied.

February 7, 1992

Order Entered at the Direction of the Court:

/s/ Michael E. Gans
Clerk, U.S. Court of Appeals, Eighth Circuit

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV88-L-523

GOOD SAMARITAN HOSPITAL, ET AL., PLAINTIFFS,

v.

LOUIS W. SULLIVAN, M.D.,
SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT

MEMORANDUM AND ORDER ON CROSS-MOTIONS
FOR SUMMARY JUDGMENT

The plaintiffs in this action under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, are six hospitals licensed as general acute care hospitals by the State of Nebraska: Good Samaritan Hospital, The Mary Lanning Memorial Hospital, Memorial Community Hospital, Memorial Community Hospital of Dodge County, Memorial Hospital (Seward), and St. Mary's Hospital Corporation. The defendant, Louis W. Sullivan, is the Secretary of Health and Human Services and is responsible for the administration of the Department of Health and Human Services (HHS), including the Medicare program. The plaintiffs challenge the defendant's conclusive application of cost limits in reimbursing Medicare providers. The plaintiffs and the defendant have filed motions for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. The defendant has filed a two-volume administrative record (A.R.) and a four-volume rulemaking record (R.R.). The parties have stipulated that the issues in this case are questions of law and that the case should be decided on the cross-motions for summary judgment. Filing 11.

I.

Under the Medicare program, health care providers are reimbursed by the federal government for expenses incurred in providing medical services to Medicare beneficiaries. *See* Title XVIII of the Social Security Act, *as amended,* 42 U.S.C. § 1395 *et seq.* (the Medicare Act). The plaintiffs are six Nebraska hospitals that participate as providers of services in the Medicare program.

Medicare providers are to be reimbursed based on the "reasonable cost" or the "customary charge", whichever is less, for services provided to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1). "Reasonable cost" is "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A). The 1972 amendments to the Act, in effect during the years in question, authorized the Secretary to utilize a schedule of limits to determine a provider's reasonable costs. The reasonable costs were to be determined "in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services. . . ." *Id.* Such regulations:

> may provide for determination of the costs of services on a per diem basis, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the costs or incurred costs of specific items or services . . . to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services . . . and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs.

Id. The regulations shall:

> take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. . . .

Id. at § 1395x(v)(1)(A)(i).

The regulations must also "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." *Id.* at § 1395x (v)(1)(A)(ii) (hereafter referred to as clause ii).

The Secretary first promulgated regulations establishing cost limits in 1974, 42 C.F.R. § 405.460, *redesignated as* 42 U.S.C. § 413.30. *See* 39 Fed. Reg. 20,164 (1974). The Secretary adopted the first schedule of cost limits that same year, 39 Fed. Reg. 30,164 (June 6, 1974), and has published updated yearly schedules prior to the beginning of the cost reporting periods to which the limits are applicable. Beginning in 1979, the Secretary incorporated into the cost limits an area wage index designed to adjust the wage component of the cost limit schedules to reflect differing wage levels among the areas in which hospitals are located. 44 Fed. Reg. 31,806 (June 1, 1979), R.R. 508. The Secretary concluded that ES-202 data from the Employment and Wages Program was the best data available for use in calculating a wage index. Under the ES-202 program, each employer in a state provides information to the State unemployment insurance agency regarding the total number of workers on

an employer's payroll during each month, total wages paid, and taxable wages, which is in turn supplied to the Bureau of Labor Statistics of the Department of Labor (BLS). A.R. 184. The Secretary chose to use ES-202 data from the "hospital group", a standard BLS reporting category. R.R. 509.

In formulating the cost limits, the Secretary also distinguished between urban and rural hospitals by determining whether a hospital was located within a Standard Metropolitan Statistical Area (SMSA) as designated by the Executive Office of Management and Budget. 44 Fed. Reg. 31,806 (June 1, 1979), R.R. 508. A SMSA is a geographical area with a large population nucleus, including surrounding communities that have a high degree of economic and social integration with that nucleus. A.R. 288. Rural hospitals routinely received a lower per diem cost limit amount than urban hospitals. The plaintiff hospitals were classified as rural, non-SMSA hospitals during the cost years in question.

For each SMSA and non-SMSA county, BLS divided the total hospital wages paid during the year by the total number of hospital employees working each month during the year to arrive at an "average monthly hospital wage." A.R. 183-186. The data regarding the number of hospital employees collected by BLS did not distinguish between full-time and part-time employees. The result is that an area with a high proportion of part-time to full-time employees on its payrolls will have a lower area monthly wage than an area with a lower proportion of part-time employees.

The Medicare program reimburses providers of services through a fiscal intermediary, in this case Blue Cross of Nebraska. Providers receive periodic interim payments based on a billing submitted to the fiscal intermediary. After the close of its fiscal year, a provider of services submits a "cost report" reflecting costs incurred during the fiscal

year and an apportionment of those costs between Medicare and non-Medicare patients. The intermediary issues a final determination of the amount payable under the Medicare Program based on the cost report and audit, if an audit is performed. Each plaintiff was supplied by Blue Cross of Nebraska with a Medicare hospital inpatient rural Nebraska per diem cost limit figure for each fiscal year under appeal as calculated by Blue Cross of Nebraska according to the Medicare cost limits regulations and cost limits schedule. No exception was available under the cost limit regulations by which a hospital could have the BLS-computed wage index recalculated to adjust for part-time employee use. In addition, the SMSA designation was the only basis the agency would recognize in determining whether a hospital was considered urban or rural. Hospitals could be reclassified as urban pursuant to 42 C.F.R. 405.460(d) (now § 413.30(d)), and hence receive a higher wage index, only if they were erroneously classified as outside a SMSA when in reality they were located within a SMSA. A.R. 199.

The plaintiffs filed appeals to the Provider Reimbursement Review Board (PRRB) challenging the "Notices of Proposed Reimbursement" for the following cost years: St. Mary's, 1980, 1982, 1983; Mary Lanning, 1981, 1982, 1983; Good Samaritan, 1981, 1982, 1983; Memorial Community, 1980, 1981, 1982, 1983; Memorial Hospital (Seward), 1980, 1982, 1983; Memorial Hospital of Dodge, 1981, 1982, 1983, 1984. Three of the hospitals filed group appeals, raising issues other than cost limits, for the following years: St. Mary's, 1981; Memorial Hospital (Seward), 1981; and Memorial Hospital of Dodge, 1980. In 1984 the plaintiffs sought to raise the cost limits issue in these appeals. (A.R. 85)

On July 22, 1988, the plaintiffs filed a request for expedited review. (A.R. 19). The Board held that it was without authority to decide the questions of whether the cost limits

were valid and whether the conclusive application of these limits was proper and granted expedited review, allowing the plaintiffs to bypass the Board's hearing procedure and obtain judicial review. It further determined that it lacked jurisdiction to hear the cost limit claims for the following cost years because the hospitals had not filed timely appeals: St. Mary's, 1981; Memorial Hospital (Seward), 1981; and Memorial Hospital of Dodge, 1980. A.R. at 3-4, 11-12, 17-18.

Plaintiff Memorial Community Hospital is located in Washington County, Nebraska. In 1983, the Office of Management and Budget determined that Washington County would be redesignated as part of the Omaha SMSA on the basis of 1980 census data, effective June 30, 1983. A.R. at 288. The Health Care Financing Administration (HCFA) did not apply the reclassification retroactively. A.R. at 590-91. Memorial Community Hospital was denied reclassification as an urban hospital for the 1980, 1981, and 1982 cost years.

The plaintiffs assert that the failure of the defendant to account for the use of part-time employees and the defendant's use of SMSA's as the sole criterion for designating hospitals as urban or rural in formulating cost limits has resulted in inaccurate reimbursement, and they seek reimbursement beyond the amount determined by the Secretary to constitute "reasonable costs" under the cost limits rules. They base their request on two alternative claims. The first is that the Secretary has a statutory duty under clause (ii) to make corrective adjustments whenever necessary to ensure that all reasonable costs are reimbursed. In the alternative they allege that the cost limit regulations and schedules are arbitrary and capricious and that they are entitled to reimbursement for their reasonable costs for the years under appeal without regard to the cost limits. Plaintiff Memorial Community Hospital also contends that the

defendant's refusal to reclassify it as being located within the Omaha SMSA beginning with its 1980 cost year was arbitrary, capricious, an abuse of discretion, and contrary to law. Finally, Memorial Hospital of Dodge County, Memorial Hospital (Seward), and St. Mary's Hospital allege that the PRRB's decision that it did not have jurisdiction over their appeals with respect to the cost limits issues in the years 1980, 1980 [*sic, should be 1981*], and 1981, respectively, was arbitrary, capricious, an abuse of discretion and contrary to law.

II

In reviewing agency actions under the Medicare statute, courts are governed by the judicial review provisions of 5 U.S.C. § 701-706 (1976). 42 U.S.C. § 1395oo(f)(1). Under 5 U.S.C. § 706(2) a reviewing court is directed to hold unlawful and set aside agency action, findings, and conclusions found to be "(a) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; [or] . . . (c) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right . . ." Courts must give deference to the interpretation given of a statute by the agency charged with its administration. *Research Medical Center v. Schweiker*, 684 F.2d 599 (8th Cir. 1982). However, when a court is presented an issue concerning an agency's interpretation of congressional intent, as opposed to an issue of whether an agency made a correct policy choice, the court need not accord a high level of deference to the Secretary's interpretation of a statute. *Bureau of Alcohol, Tobacco & Firearms v. Federal Labor Relations Auth.*, 464 U.S. 89, 98 n. 8 (1983) ("When an agency's decision is premised on its understanding of a specific congressional intent, however, it engages in the quintessential judicial function of deciding what a statute means. In that case, the agency's interpretation . . . may be influential, but it cannot bind a court")

The first issue is whether the Secretary has the authority to apply the cost limit schedules on a conclusive basis, or whether the Secretary must instead allow the plaintiffs an opportunity, under clause (ii), to demonstrate that they are entitled to reimbursement of reasonable costs beyond the amount already determined reasonable under the cost limit schedule.

The plaintiffs contend that their reimbursement under the cost limit schedule was inadequate due to the failure of the BLS data, used in formulating the wage index, to distinguish between full-time and part-time employees. BLS received data on the total hospital wages paid and the total number of hospital employees working during a given month. From this data the BLS computed an average monthly hospital wage. The number of employees counted included all personnel, including part-time employees. A.R. 184. Under this method every hospital employee who worked during a month was counted with equal weight. Therefore a hospital that has total monthly wages of $100,000 and employs 100 full-time employees would have an average monthly hospital wage of $1,000. But if the same hospital, again with total monthly wages of $100,000 employed 200 part-time employees, BLS calculations would show an average monthly wage of only $500. Thus, if rural hospitals in a given state employ a high percentage of part-time employees, the non-SMSA wage index for these hospitals will be distorted downward. In a study dated October 11, 1983, the Nebraska Hospital Association reported that after reviewing the percentage of part-time employees for Nebraska and the nation it was apparent that Nebraska exceeded the national average. It found that the national average of part-time employees in non-SMSA areas in 1980 was 26%, while the average of part-time employees in non-SMSA areas in Nebraska was 44%. It noted that Nebraska would experience a substantial increase in its wage index

if it were adjusted for the impact of part-time employees. A.R. 129, 132.

The plaintiffs (with the exception of Memorial Hospital, Seward, who does not join in this challenge) also allege that they were denied adequate reimbursement under the non-SMSA designation due to the fact that they incurred costs comparable to those of SMSA hospitals in Nebraska in the period 1980 through 1983. Memorial Hospital of Dodge County is located 6 miles from the Omaha SMSA, Memorial Community Hospital is located 25 miles from the Omaha SMSA, St. Mary's is located 50 miles from the Omaha and Lincoln SMSA's, Good Samaritan is located 124 miles from the Lincoln SMSA and Mary Lanning is located 100 miles from the Lincoln SMSA and 160 miles from the Omaha SMSA. The plaintiffs located within 50 miles of a SMSA allege that they directly competed with SMSA hospitals to attract staff. Good Samaritan and Mary Lanning allege that they had to offer SMSA-level wages to attract staff out to their remote locations. The hospitals have submitted data showing that their average hourly wages and average starting salaries for registered nurses were comparable to the urban hospitals in Nebraska. A.R. 128, 422, 533, 831, 927. For these reasons the plaintiffs believe they are entitled to corrective adjustment under clause (ii).

The Secretary disagrees and contends that section (1)(a) gives him the authority to apply the cost limits as conclusive evidence of which costs are reasonable rather than having to develop cost schedules on a case-by-case basis. To adopt the plaintiffs' interpretation of clause (ii), the Secretary argues, would be to render meaningless the regulations established to determine reasonable costs. Instead, he believes that clause (ii) only authorizes a year-end "book balancing" adjustment of the monthly installments received by the provider to ensure that the provider receives what it is due under the cost limits as applied. Under the Secre-

tary's view clause (ii) does not authorize the reimbursement of any costs which exceed the cost limits.

I disagree. The 1972 amendments must be construed to authorize the Secretary to develop and apply presumptive, not conclusive, cost limits. The legislative history of the 1972 amendments supports this finding. ". . . [T]he evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and presumptive basis—relatively high costs that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable . . ." H.R. Rep. No. 231, 92nd Cong., 2nd Sess., *reprinted in* 1972 U.S. Code Cong. & Ad. News, 4989, 5070. "Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." *Id.* at 5071.

The Secretary claims that to allow the plaintiffs reimbursement under clause (ii) would nullify the purpose of formulating cost limits in the first place. Other courts that have considered this issue have disagreed with that position.

> Prior to the 1972 amendments, reimbursements were calculated individually for each provider on a retrospective basis. That method generally led to reimbursement for all costs which providers had incurred, whether necessary and efficient or not, because it was extremely difficult for the Secretary to establish that a specific cost was unreasonable . . . The use of prospective payments regulated by a schedule of limits shifted the burden of proving the reasonableness of costs exceeding the presumptive limit to the provider . . ." (citations and footnote omitted)

Regents of U. of Cal. v. Heckler, 771 F.2d 1182, 1190 (9th Cir. 1985)

> This interpretation does not, as the Secretary suggests, render the 1972 amendments a "nullity". As the legislative history indicates, presumptive cost limits can serve several useful purposes . . . [T]he cost limit methodology enables intermediaries to disallow costs in the first instance without having to engage in a case-specific evaluation of reasonableness. Before the adoption of the cost limit methodology, an intermediary could disallow a provider's costs in the first instance only to the extent it would establish that the provider's costs were "substantially out of line" with comparable facilities in the provider's geographic vicinity. Congress apparently came to regard this approach as adequate, and determined that the cost limit methodology would provide a more effective means for evaluating reimbursement claims . . ." (citation and footnote omitted)

Medical Center Hospital v. Bowen, 839 F.2d 1504, 1512 (11th Cir. 1988)

I agree that to allow the plaintiffs the opportunity to demonstrate that their costs in excess of the cost limits were reasonable does not render useless the cost limits themselves. The Secretary has a statutory duty under clause (ii) to ensure that the necessary corrective adjustments are made whenever the methods of cost calculation fail to reimburse a provider for its reasonable costs. *St. Paul-Ramsey Medical Center v. Bowen,* 816 F.2d 417 (8th Cir. 1987). There the plaintiff hospital sought review of the Secretary's decision to deny reimbursement for increased costs of operating a graduate medical program for the fiscal year ending December 31, 1980. The court held that section (1)(a) imposes a statutory duty upon the Secretary to reimburse adequately all reasonable costs whenever the chosen method

of cost calculation fails to reimburse adequately all reasonable costs, and that the Secretary's refusal to grant the hospital a retroactive corrective adjustment violated his statutory duty. It ordered the Secretary to apply retroactively the 1980 Indirect Teaching Cost Adjustment, a regulation that was not in effect during the year in question.

Similarly, the Circuit Court of Appeals for the District of Columbia has held that clause (ii) allows the Secretary to adjust provider reimbursement upon proof that his methods of determining costs, including the cost limit rules, resulted in inadequate or excessive reimbursement. At issue in *Georgetown Univ. Hosp. v. Bowen*, 821 F.2d 750 (D.C. Cir. 1987) was the ability of the Secretary to formulate cost limit rules and to apply them retroactively. In 1981 the Secretary had modified the wage-index to exclude data on wages paid by federally-owned hospitals, which he believed reduced the accuracy of the index. He did so without allowing for the required notice and comment period. Seven hospitals challenged his action in District Court. The court agreed that the Secretary's actions violated the Administrative Procedure Act (APA). The Secretary did not appeal the ruling, and instead settled the provider's accounts by using the wage-index rule in effect prior to his modifications. Three years later the Secretary reissued the 1981 wage-index rule and complied with the notice and comment requirements. This time, however, he made the rule retroactive to July 1, 1981, which was exactly the same accounting period that would have been covered had the District Court not struck down the rule.

The plaintiff hospitals again filed suit, this time challenging the rule's retroactive application. At no point in the litigation did the Secretary dispute the fact that Congress amended the Medicare statute in 1972 to authorize only prospective cost limit rules. He instead argued that clause (ii) authorized him to promulgate retroactive cost limit

rules. The court held that the Secretary's retroactive promulgation was not authorized by clause (ii). The court found a critical distinction between the power to promulgate retroactive rules of general application and the power to make retroactive corrective adjustments to particular providers when their aggregate reimbursement was either inadequate or excessive.

> The former power—if it existed—would be exceedingly broad, for it would permit the Secretary to issue a modified cost limit rule, and then automatically apply that rule across the board to all providers who had been reimbursed under the predecessor rule. The latter power, however, is far more limited, for it only allows the Secretary to adjust the reimbursements of particular providers upon proof that his "methods of determining costs" (including his cost-limit rules) resulted in inadequate or excessive reimbursements to those providers.

Id. at 759.

This decision was affirmed in *Bowen v. Georgetown Univ. Hosp.*, ____ U.S. ____, 109 S.Ct. 468, 57 U.S.L.W. 4057 (1988). The defendant argues that *Bowen* has overruled *St. Paul-Ramsey, supra,* and *Regents of Univ. of Calif., supra,* and that under the holding in *Bowen* he is not authorized to make corrective adjustments beyond what the applicable cost limits already allow.

To begin with, *Bowen* did not overrule *St. Paul-Ramsey* or *Regents of Univ. of Calif.* The *Bowen* court addressed the issue of the retroactive promulgation of cost limit rules and agreed with the lower court's findings.

> . . . [W]e agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to re-

> imbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases. The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudication, not to rulemaking. /1.

57 U.S.L.W. at 4059.

Footnote 1 states in pertinent part that ". . . Other courts, without deciding whether clause (ii) permits rulemaking, have held that it requires the Secretary to make case-by-case adjustments to reimbursement determinations. *E.g., St. Paul-Ramsey Medical Center v. Bowen,* . . . ; *Regents of the University of California v. Heckler,* . . ." This footnote makes clear that the Court does not consider *St. Paul* and *Regents* to be in conflict with its holding. The Court went on to state that because clause (ii) refers to "a provider", its intent is to authorize a case-by-case inquiry into the accuracy of reimbursement determinations for individual providers, and not to permit modifications to the cost-method rules in their general formulation.

For the foregoing reasons I find that the plaintiffs are entitled to consideration of their reasonable expenses in excess of the cost limit rules in effect for the years under appeal.

The plaintiffs contend that if they are successful in obtaining reimbursement in excess of the cost limits for the years at issue, they are also entitled to an adjustment to their hospital specific rate under the Prospective Payment System (PPS), which is used for cost periods beginning on or after October 1, 1983. For the first four years of the PPS, a portion of a hospital's PPS payment is based on the hospital's reasonable costs in a prior "base year". All of the plaintiffs have their PPS base year (generally fiscal year 1982) as one of the years under appeal in this case. The defendant has

agreed that if the plaintiffs are successful in obtaining reimbursement that their PPS payment should be adjusted to reflect the additional base year. (Defendant's memorandum at p. 3).

III

The next issue is whether the Secretary's refusal to retroactively reclassify Memorial Community Hospital as an urban hospital was arbitrary and capricious. Memorial Community Hospital, located 20 miles from the Omaha SMSA, was classified by the Secretary as a rural hospital for the 1980, 1981, and 1982 cost years. In 1983 the Office of Management and Budget reclassified Washington County as part of the Omaha SMSA. The revised designation was obtained by applying new SMSA standards to selected demographic data produced by the 1980 decennial census. A.R. 590. The HCFA did not apply the classification retroactively. When it notified the hospital of their decision, the HCFA explained that new SMSA designations do not become effective until notification is given of the change in status, and that the new designation would not become official until after formal publication in June 1983. A.R. 590. The HCFA agreed that to adopt new SMSA designations retroactively would benefit those providers who were reclassified into a SMSA, but noted that those who lost their SMSA designation under the new classification system would then be subject to retroactive reduction of reimbursement, something the HCFA felt would not be equitable.

> We do not believe that this would be equitable because providers would not have known in advance of the cost reporting periods to which the limits apply what their official status could be expected to be. The idea that cost limits would be determined prospectively, that a provider would

> know the limit of Medicare reimbursement in advance of the cost reporting period to which it would be applied, was a major premise expressed in the committee reports which accompanied the law authorizing the cost limits.

A.R. 591.

For the Secretary to allow otherwise would have been to violate the Supreme Court's prohibition in *Bowen* against across-the-board retroactive modifications to the cost limit rules. I find that the refusal to reclassify Memorial Community Hospital was not arbitrary or capricious.

III

The final issue is whether the PRRB improperly denied jurisdiction over the appeals of three cost years. The PRRB denied jurisdiction over the appeals of St. Mary's Hospital for fiscal year 1981 (A.R. 3), Memorial Hospital (Seward) for fiscal year 1981 (A.R. 11) and Memorial Hospital of Dodge County for fiscal year 1980 (A.R. 17) on the ground that the cost limit appeals were not filed within 180 days of the date of the Notice of Program Reimbursement as required by 42 U.S.C. § 1395oo(a)(3). Each of the hospitals had argued that its appeal of the cost limit issues should be considered as having been timely filed because each of them had filed a timely appeal on other issues raised in group appeals for the same years in question. There is no dispute that the plaintiffs did not file their appeals on the cost limit issue within 180 days. Nevertheless, they contend that they should be allowed to raise their challenge to the cost limits for these years because they were participants in timely filed group appeals.

The Medicare Act provides two avenues of appeals. Under 42 U.S.C. § 1395oo(a) (section (a)) any provider of services that has filed a required cost report may obtain a

hearing with respect to such cost report. This request for a hearing must be filed within 180 days after notice of the intermediary's final decision. 42 U.S.C. § 1395oo(a)(3). The second is a group appeal pursuant to 42 U.S.C. § 1395oo(b) (section b). Under this provision a group of providers may file a group appeal if the matters in controversy involve a common question of fact or law. The plaintiffs cite 29 C.F.R. § 405.1841(a) (1974), *redesignated as* 42 C.F.R. § 405.1841, in support of their claim. That section states in pertinent part that "[t]he request for a Board hearing must be filed in writing with the Board within 180 days . . . Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof." But as the defendant points out, this section is not applicable to group appeals. 42 C.F.R. § 1837, entitled "Group appeal", states in subsection (b) that "[a] single provider involved in a group appeal that also wishes to appeal issues that are not common to the other providers in the group must file a separate hearing request (see § 405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable." Those requirements include the one that the provider file a written request within 180 days of the notice of the intermediary's determination. *See* 42 C.F.R. § 405.1835(a)(2), which incorporates the time limits set forth in 42 C.F.R. § 405.1841(a). Thus, the fact that the plaintiffs were participants in a timely filed group appeal does not allow them to raise other issues not common to the group outside the 180-day period. The PRRB properly found that it lacked jurisdiction to review the challenges to the wage index for these cost years.

IT IS ORDERED that: (1) the plaintiffs' motion for summary judgment, Filing 12, is granted on the issue of corrective adjustment of cost limit rules and is otherwise denied; and (2) that the defendant's motion for summary judgment, Filing 14, is granted on all issues, except the issue of corrective adjustment of cost limit rules.

Dated February 16, 1990.

BY THE COURT

/s/ Warren K. Urbom
United States District Judge

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5054

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, Maryland 21202

Re: Good Samaritan Hospital, Provider No. 28-0009, Case No. 88-5054, FYEs – December 31, 1981, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid.

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y		Amount
December 31, 1981	–	$223,500
December 31, 1982	–	$243,000
December 31, 1983	–	$112,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/hr

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5053

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: The Mary Lanning Memorial Hospital, Provider No. 28-0032, Case No. 88-5053, FYEs – December 31, 1981, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y		Amount
December 31, 1981	–	$222,000
December 31, 1982	–	$227,000
December 31, 1983	–	$200,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To: JRB: 88-5055
Location: Professional Bldg. Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: Memorial Community Hospital, Provider No. 28-0047, Case No. 88-5055, FYEs – December 31, 1980, 1981, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y		Amount
December 31, 1980	–	$29,000
December 31, 1981	–	$54,000
December 31, 1982	–	$59,000
December 31, 1983	–	$71,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5052

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: Memorial Hospital of Dodge County, Provider No. 28-0077, Case No. 88-5052, FYEs – December 31, 1981, 1982, 1983, and 1984, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y	Amount
December 31, 1981 –	$130,000
December 31, 1982 –	$157,000
December 31, 1983 –	$157,000
December 31, 1984 –	$ 85,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5051

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: Memorial Hospital (Seward), Provider No. 28-0058, Case No. 88-5051, FYEs – September 30, 1980, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y	Amount
September 30, 1980 –	$31,000
September 30, 1982 –	$60,000
September 30, 1983 –	$14,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5056

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: St. Mary's Hospital, Provider No. 28-0062, Case No. 88-5056, FYEs – September 30, 1980, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y	Amount
September 30, 1980 –	$36,000
September 30, 1982 –	$59,000
September 30, 1983 –	$35,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 90-15772
D.C. No. CV 89-2714-DLJ

MT. DIABLO HOSPITAL, PLAINTIFF-APPELLANT,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLEE.

Appeal from the United States District Court
for the Northern District of California
D. Lowell Jensen, District Judge, Presiding

No. 90-15857
D.C. No. CV 88-282-EDP

MEMORIAL HOSPITALS ASSOCIATION, PLAINTIFF-APPELLANT,

v.

OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLEE.

Appeal from the United States District Court
for the Eastern District of California
Edward D. Price, District Judge, Presiding

Argued and Submitted
August 20, 1991—San Francisco, California
Filed April 28, 1992

Before: Dorothy W. Nelson, Cynthia Holcomb Hall, and Ferdinand F. Fernandez, Circuit Judges.

Per Curiam

COUNSEL

William Uhle, Thummel & Uhle, Portland, Oregon; John R. Faust, Jr., Mildred J. Carmack, Schwabe, Williamson & Wyatt, Portland, Oregon, for the plaintiff-appellants.

Charles H. Turner, United States Attorney, District of Oregon; Jennifer J. Martin, Special Assistant United States Attorney, Portland, Oregon, for the defendant-appellee.

OPINION

PER CURIAM:

Mt. Diablo and Memorial Hospitals appeal from the district courts' grants of appellee Secretary of Health and Human Services Louis Sullivan's ("Secretary") motions for summary judgment. We consider whether the district courts erred in concluding (1) that the Secretary's methods for determining routine cost limits for Medicare reimbursement are not arbitrary and capricious and (2) that the providers were not entitled to retroactive corrective adjustments to compensate them for the effects of those cost limits. For the reasons stated below, we affirm the judgment in *Memorial Hospitals v. Sullivan*, No. 90-15857, but reverse and remand the decision in *Mt. Diablo Hospital v. Sullivan*, No. 90-15772.

I

BACKGROUND

Appellants provide health care services to eligible aged and disabled persons under the Medicare program, 42 U.S.C. § 1395 et seq. For the cost years at issue in this case,[1] providers were reimbursed for daily routine service costs at a rate equivalent to the lesser of the "reasonable cost" of the services or the "customary charges" for the services. Appellants challenge the methods used by the Secretary to determine the "reasonable cost" of providing routine care.

In 1972, Congress amended the Medicare Act to give the Secretary broad discretion to define reasonable costs.[2] The amendments were motivated by the desire to contain costs arising from "variations in the efficiency of operation [and] the provision of amenities in plush surroundings." H.R. Rep. No. 231, 92nd Cong., 2d Sess., *reprinted in* 1972 U.S.C.C.A.N. 4989, 5069 [hereinafter House Report]. Previously, providers had been reimbursed for their actual

[1] Memorial challenges the reimbursement it received for the fiscal year ending in 1980. Mt. Diablo challenges its reimbursement for the fiscal years ending in 1982 and 1983.

[2] 42 U.S.C. § 1395x(v)(1)(A) states;

> Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs.

incurred costs. The new regulations excluded "any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A).

In 1974, the Secretary began the yearly publication of a schedule of routine cost limits pursuant to the 1972 amendments. The schedules were based on factors the Secretary found "appropriate and practical," including types of services furnished, geographic area, and institutional size. The schedules categorized hospitals by the per capita income of the location area and by number of beds. In 1979, the Secretary began using a wage index to calculate the reasonable cost of labor. The index was based on reports of quarterly hospital wages made to the Bureau of Labor Statistics of the Department of Labor ("BLS"). The average wage for a geographic area was computed by dividing the total hospital wages paid in one year by the total number of hospital workers in the area. The index was then formulated by dividing the average local wage by the national average. The resulting index value for each area would reflect the wage level for that area relative to the national average. *See Health Care Financing Administration Medicare Program; Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1981,* 46 Fed. Reg. 33637, 33638-89 (June 30, 1981) [hereinafter *1981 Schedule of Limits*].

The BLS data was criticized for several perceived flaws, including its age and its failure to standardize for factors such as the variation in occupational mix and proportion of part-time workers. The data's effective assumption that all employees worked full-time was detrimental to areas that employed large numbers of part-time workers. Areas in which hospitals employed large numbers of part-time employees were determined to have lower costs per employee,

and consequently assigned lower index values, than areas in which hospitals had the same costs but a different mix of part-time and full-time workers. Commentators also noted a distorting effect from the inclusion of federal and state hospital wage data in the index. The Secretary defended the use of the BLS data, stating that the indices employed "the most reliable data available," *Health Care Financing Administration Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1980,* 45 Fed. Reg. 41868, 41871 (June 20, 1980).

In 1983, Congress ordered the Secretary to conduct a study to develop a wage index that accounted for the deficiencies in the BLS data. According to the Secretary, the group which eventually conducted the study concluded that the failure to account for part-time workers was the "most serious deficiency" in the BLS data. In 1986, the Secretary finally revised the index to distinguish between part-time and full-time employees.

For the cost years at issue in this case, which were governed by the pre-1986 indices, appellants' costs exceeded the routine cost limits. Each appealed to the Provider Reimbursement Review Board ("PRRB") as required under the Medicare Act, 42 U.S.C. § 1395oo(a). Memorial sought reimbursement for costs in excess of Medicare's routine cost limits. Mt. Diablo requested an order allowing it to go directly to federal court to challenge the cost limits. The PRRB determined that it had no power to determine the validity of the wage index and authorized the parties to seek judicial review in the district court under 42 U.S.C. § 1395oo(f)(1).

Memorial and Mt. Diablo filed suit in the district courts in May 1988 and July 1989, respectively. Memorial sought a retroactive corrective adjustment to its reimbursement based on the "errors" in the wage index or, alternatively,

an exemption from the routine cost limits on the grounds that the inaccurate wage index was "an extraordinary circumstance beyond its control."[3] Mt. Diablo sought both a declaration that the methodology used in calculating the area wage index was invalid and a retroactive corrective adjustment. The district courts granted the Secretary's motions for summary judgment in each case. Both hospitals timely appealed.

II

STANDARD OF REVIEW

We review the district court's grant of the Secretary's motion for summary judgment de novo. *Vallejo Gen. Hosp. v. Bowen,* 851 F.2d 229, 230-31 (9th Cir. 1988).

The Secretary's Medicare reimbursement policy is reviewed under the Administrative Procedure Act (APA), 42 U.S.C. § 1395oo(f)(1). Under the APA, we must determine if the Secretary's action was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A). In making this determination, we "must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 416 (1971).

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[3] There are two basic mechanisms for the adjustment of cost limits where the general rules do not adequately reimburse the health care provider for its reasonable costs—exemptions and retroactive corrective adjustments. All exemptions may be granted where, for example, excess expenses are attributable to provision of atypical services or "extraordinary circumstances." It will be allowed "only if the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the [the fiscal agent of the Secretary]." *Hennepin County v. Sullivan,* 883 F.2d 85, 87 (D.C. Cir. 1989), *cert. denied,* 493 U.S. 1043 (1990); 42 C.F.R. § 413.30(e), (f). Memorial does not appeal the denial of its request for an exemption.

III

ANALYSIS

A. Calculation of Cost Limits

Mt. Diablo argues that the pre-1986 method for calculating routine cost limits was arbitrary and capricious for two reasons. First, they contend that the Secretary ignored a relevant factor—the discrepancies in the wage index caused by regional variations in the use of part-time and full-time employees. Second, they argue that the Secretary failed to respond adequately to public comments on this issue.

1. Failure to consider a relevant factor.

Mt. Diablo points to three comments on the proposed use of the BLS data as evidence that the Secretary knew about and failed to consider the distortion caused by part-time workers.[4] In 1979, the Hospital Association of New York State (HANYS) commented: "A wage level comparison based upon [the BLS data relating to service workers] can be distorted by the regional variations in mix of part-time employment, hours worked per week, overtime

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[4] Mt. Diablo also points out that in the July 3, 1984, Federal Register the Secretary acknowledged that "the most serious deficiency" of the BLS data was its failure to control for part-time workers. *Health Care Financing Administration Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges on or After October 1, 1984, and Update Factors Effective with Cost Reporting Periods Beginning on or After October 1, 1984,* 49 Fed. Reg. 27438, 27439 (July 3, 1984). It relies upon the adoption in 1986 of a wage index accounting for part-time workers as further evidence of the rule's arbitrariness. Evidence of subsequent developments, however, is not considered in a review of informal agency rulemaking. Review is limited to the administrative record before the Secretary at the time of his decision. *See Citizens to Preserve Overton Park,* 401 U.S. at 420.

pay, etc." *Comments of the Hospital Association of New York State on the Proposed Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning On Or After July 1, 1979,* April 30, 1979, at 2 [hereinafter *Comments of HANYS*].[5]

In 1980, the Secretary received two additional comments on the wage index. The Hospital Association of Rhode Island advocated use of data from the American Hospital Association (AHA) because of the distortion caused by BLS' failure to account for part-time workers. An accounting firm also noted the impact of the omission, stating that "those areas with a large volume of part-time hospital workers will rate lower than areas with more full-time employment, even though their actual wage scales may be higher."

We review agency actions under the APA to determine if the agency has adequately considered all "relevant factors." *See Citizens to Preserve Overton Park,* 401 U.S. at 416. An agency rule may be found to be arbitrary and capricious when

> the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

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[5] However, HANYS also acknowledged:

> [T]here is, at the present time, no data source which is external to the hospital economy that can be used to reasonably adjust the differences between salaries. The development of such data certainly is possible but would involve considerable time, difficulty, and expense to develop.

Comments of HANYS, at 2.

Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co., 463 U.S. 29, 43 (1983).

We may conclude that an agency has ignored relevant factors where its action amounts to an " 'artificial narrowing of options' [which] is antithetical to reasoned decision-making. . . ." *International Ladies' Garment Workers Union v. Donovan,* 722 F.2d 795, 817 (D.C. Cir. 1983) (quoting *Pillai v. Civil Aeronautics Bd.,* 485 F.2d 1018, 1027 (D.C. Cir. 1973)) (internal citation omitted). Agency actions cannot be sustained where the agency has failed to consider significant alternatives. *See ILGWU,* 722 F.2d at 815-16 (agency failed to consider "substantial testimony" and "specific proposals" for alternative actions). Similarly, an action will not be upheld where the agency has intentionally omitted evidence from consideration or where there is nothing in the record to support the agency's decision. *See Pillai,* 485 F.2d at 1027; *California Hosp. Ass'n v. Schweiker,* 559 F. Supp. 110 (C.D. Cal. 1982) (in drafting documents supporting a proposal, agency intentionally omitted facts which undermined its position), *aff'd,* 705 F.2d 466 (9th Cir. 1983).

Applying these criteria, we cannot conclude that the Secretary acted arbitrarily or capriciously by not factoring the use of part-time workers into the wage index. A relatively insignificant percentage of the comments received during the period leading up to the adoption of the 1981 routine cost limits were directed at the part-time worker issue. Most comments were directed at other concerns, particularly a fundamental change in the reimbursement rate and the proposed methods of classifying care providers. Additionally, the record suggests that, far from intentionally omitting the issue from consideration, the agency recognized the growing concern about the part-time worker issue and planned to address it in a comprehensive manner. Indeed, the agency proposed in 1981 to develop an appropriate database

by modifying the Medicare cost report, but the proposal was delayed in part because of opposition from the hospital industry.

Moreover, the agency's action was well within the reasonable bounds of its Congressional mandate. The agency was given broad powers to promulgate regulations providing for the determination of the costs of services, including the establishment of limits on costs to be recognized as reasonable. *See* 42 U.S.C. § 1395x(v)(1)(A). A court must accord an agency's statutory interpretation "substantial deference," since "presumably [the agency] has brought its expertise to bear in formulating the regulation. . . ." *American Hosp. Mgmt. Corp. v. Harris,* 638 F.2d 1208, 1212 (9th Cir. 1981). Review in such a case "is limited to determining whether the regulation is reasonably related to the purpose of the relevant enabling legislation. . . ." *Id.*

Here, Congress recognized that "the initial ceilings will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. . . . The data that are available for this purpose will often be less than perfectly reliable. . . ." House Report, *supra,* at 5070. To forbid the agency from adopting routine cost limits until perfect data concerning a relatively minor issue is developed would contravene the agency's mandate. This is particularly true in the case of part-time workers, since Congress had recognized the need for ongoing refinements and the agency had proposed to remedy the problem.

Mt. Diablo also argues that the Secretary should have used AHA data, which was weighted to account for the part-time worker issue, in formulating the wage index. It claims this data was available to the Secretary as early as 1979, and that it was used in calculating other portions of the wage index.

The Secretary did not indicate why (or whether) the BLS data was preferable to the AHA data with regard to the

part-time worker issue. But "we will uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned," *Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc.,* 419 U.S. 281, 286 (1974). That path is evident here. The record indicates that the decision to use the BLS data was based upon a number of factors, including variations in over-time, and variations in hospital occupational categories. The agency stated in the June 20, 1980, Federal Register that it did "not bas[e] the wage index on AHA data because these data are less complete than those supplied by the BLS, since they do not include all of the occupational categories comprised by the BLS data base." *Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs of Cost Reporting Periods Beginning on or after July 1, 1980.* 45 Fed. Reg. 41868, 41872 (1980). The agency simply chose one imperfect database over another while seeking to develop data superior to either. This choice was rational. The Secretary concluded that the BLS data were "the most reliable data available" at the time. *See Schedule of Limits, supra* at 33639. Given the narrow scope of review, we cannot regard the Secretary's decision to use that data as arbitrary and capricious.[6]

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[6] The Eighth Circuit has reached the same conclusion on similar facts. In *Good Samaritan Hosp. v. Sullivan,* 952 F.2d 1017 (8th Cir. 1991), rural Nebraska hospitals, which exceeded the Secretary's cost schedules, claimed that the wage-index regulations were arbitrary and capricious for failing to account for the use of part-time employees. Like appellants in this case, the hospitals claimed that the Secretary knew of the distortion but did nothing to correct it. The Eighth Circuit rejected the hospitals' claim, holding:

> At the time the regulations were in place, the Secretary claims that they were based upon the latest available data. There is nothing arbitrary or capricious about the cost limit methodology used by the Secretary. Both the wage index and the rural/urban distinction were based on objective data and regulations, and we hold the SMSA-based cost limit regulations are not arbitrary or capricious.

Id. at 1025 (citations omitted).

2. Failure to respond adequately to public comments.

Mt. Diablo argues that the routine cost limits are invalid because the Secretary "did not respond specifically" in the Federal Register to comments about the part-time worker issue. The Secretary explained his use of the BLS data only by saying that they were "the most reliable data available." *See Schedule of Limits, supra* at 33639. Mt. Diablo contends that the Secretary was obligated to explain the reasoning behind that conclusion.

A rule may be invalidated under the APA because an agency fails to explain the rule adequately. *United States v. Garner,* 767 F.2d 104, 117 (5th Cir. 1985); *see also International Bhd. of Teamsters v. United States,* 735 F.2d 1525, 1532 (D.C. Cir. 1984) (in absence of "*other* indication" of why the agency acted as it did, "bald assertion" that reporting items are "unnecessary" cannot be upheld). Nevertheless,

> [t]here is no obligation to make references in the agency explanation to all the specific issues raised in comments. The agency's explanation must simply enable a reviewing court to see what major issues of policy were ventilated by the informal proceedings and why the agency reacted to them the way it did.

South Carolina ex rel. Tindal v. Block, 717 F.2d 874, 886 (4th Cir. 1983) (internal citations and quotations omitted), *cert. denied,* 465 U.S. 1080 (1984). In making the "keystone" inquiry whether the Secretary "engaged in reasoned decision-making," *ILGWU,* 722 F.2d at 815, the reviewing court is to consider the larger administrative record. 5 U.S.C. § 706.

As the preceding discussion explains, the record indicates that the Secretary acted reasonably in formulating the wage index. Moreover, given the fact that the part-time worker

issue was of minor significance at the time the wage index was adopted, the Secretary had no obligation to provide a specific response to the comments about it. The Secretary's general response to the concern over the validity of the BLS data was appropriate.

B. Retroactive Corrective Adjustments

The Medicare statute, 42 U.S.C. § 1395, requires the Secretary to make "retroactive corrective adjustments" for hospitals whose reimbursement under the cost rules "proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii). Mt. Diablo and Memorial hospitals seek a retroactive corrective adjustment because they claim that the old cost rules undercompensated them by failing adequating to take into account their labor costs. The district courts denied relief on different grounds.

The statute at issue, 42 U.S.C. § 1395x(v)(1)(A), provides that "[t]he reasonable cost of any services . . . shall be determined in accordance with regulations establishing the method or methods to be used . . . in determining such costs. . . . Such regulations shall . . . (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." On its face, the plain language of the statute appears to require the Secretary to make a retroactive adjustment when its cost method produces an inequitable result in a particular case.

In *Regents of the Univ. of California v. Heckler,* 771 F.2d 1182, 1189 (9th Cir. 1985), the Secretary contended that this provision requires "no more than a year-end balancing of the books." *Id.* at 1189. We rejected that argument for four reasons. First, such a limited reading was inconsistent with the plain language of the statute, which requires adjustments whenever a hospital's compensation is "inadequate or ex-

cessive," not merely when it has been calculated incorrectly. *Id.* at 1189-90. Second, a different section—42 U.S.C. § 1395(g)—already provides for a year-end adjustment to rectify accounting errors made in calculating the cost reimbursements. To read section 1395x(v)(1)(A)(ii) as requiring nothing more would make it redundant. *Regents,* 771 F.2d at 1189.

Third, the 1972 Medicare amendments, which established the cost methods at issue in *Regents* and here, "merely added another method of cost calculation to those already recognized as legitimate by the statute." *Id.* Prior methods had already been determined to be subject to the provisions for retroactive adjustment. To conclude that this new method was immune from retroactive adjustments on the basis of inadequate reimbursement would lead to the perverse result of "render[ing] the corrective adjustment clause nugatory in the case of one particular method of calculating costs." *Id.* at 1190. Finally, *Regents* reviewed the legislative history of the section, which seemed unambiguously to establish that the Secretary's cost limits were *presumptive,* not conclusive, *Id.*. Thus, *Regents* concluded that hospitals were entitled to seek a retroactive corrective adjustment on the grounds that the cost limits, *even though correctly applied,* worked an injustice in their particular circumstance. *Id.* at 1191.

Under *Regents*, the hospitals are entitled to make their case for a retroactive corrective adjustment. The only question in this case is whether *Regents* remains good law after the Supreme Court's decision in *Bowen v. Georgetown University Hospital,* 488 U.S. 204 (1988), which also applied section 1395x(v)(1)(A)(ii).

In *Georgetown,* the Secretary's 1981 cost rule had been struck down by a court, and the Secretary sought to reimpose the rule retroactively and collect the "overpayments" it had made to *all* hospitals during the time the rule had

been held invalid. The Supreme Court rejected the Secretary's argument, holding:

> This provision [1395x(v)(1)(A)(ii)] on its face permits some form of retroactive action. We cannot accept the Secretary's argument, however, that it provides authority for the retroactive promulgation of cost-limit rules. To the contrary, we agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases. The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudication, not to rulemaking.

Id. at 209. In so doing, *Georgetown* cited *Regents* with apparent approval, distinguishing it from those cases which had permitted the Secretary to engage in retroactive rulemaking. *Id.* at 209-10 n.1.[7]

Thus, the rule established by the Supreme Court in *Georgetown* is that case-by-case adjustments in the interests of justice are allowed under clause (ii), but rules of general applicability are not. The only question, therefore, is whether what Mt. Diablo and Memorial are seeking constitutes across-the-board rulemaking or a case-by-case adjustment. It seems clear that they intended to seek the latter. In fact, the district courts in both cases recognized that

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[7] Regarding *Regents,* the Supreme Court had this to say: "Other courts, without deciding whether clause (ii) permits rulemaking, have held that it requires the Secretary to make case-by-case adjustments to reimbursement determinations. *E.g.,* . . . *Regents of the University of California v. Heckler,* 771 F.2d 1182, 1188-89 (CA9 1985)." *Georgetown,* 488 U.S. at 210 n.1.

the hospitals were seeking individualized adjustments to the aggregate amount of their reimbursement under clause (ii), not revisions in the cost methods used by the Secretary.[8]

The Secretary suggests that, notwithstanding the hospitals' characterization of their own claim, they really seek rulemaking changes. We do not agree. Unlike the Secretary's proposed changes in *Georgetown*, which would affect all hospitals under the rules, the adjustments sought by Mt. Diablo and Memorial would apply only to them. The situation of the hospitals is similar to the situation in *Regents*: the hospital there was entitled to seek reimbursement under clause (ii) over and above the cost limits imposed by the Secretary, even though its claims were based on exceptions the Secretary had already determined not to apply. *See Regents,* 771 F.2d at 1185-86. Both the facts of this case and Ninth Circuit precedent suggest that what the hospitals are seeking here is a case-by-case adjustment, not retroactive rulemaking.[9]

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[8] Both hospitals *also* sought changes in the Secretary's cost methods; those claims are dealt with in Part III.A, *ante*. There is nothing in the Medicare statute which prohibits hospitals from seeking both a general change in the law and a specific adjustment for their particularlized circumstances.

[9] The Eighth Circuit has concluded in a very similar case that what the hospitals are seeking really constitutes rulemaking. *Good Samaritan Hospital v. Sullivan,* 952 F.2d 1017, 1023-24 (8th Cir. 1991); *see also Hennepin County v. Sullivan,* 883 F.2d 85, 92-93 (D.C. Cir. 1989) (stating same in dictum; parties conceded the issue at oral argument), *cert. denied,* 493 U.S. 1043 (1990). However, the conclusion in both those cases was based on the determination that "clause (ii) merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year." *Good Samaritan,* 952 F.2d at 1024; *See Hennepin,* 883 F.2d at 93 (clause (ii) allows only review of accounting calculations). As noted above, this Circuit has *expressly* rejected that view for a number of sound reasons, *see Regents,* 771 F.2d at 1189, and nothing in *Georgetown* even intimates that clause (ii) is merely an accounting provision.

We therefore conclude that the hospitals are entitled to make a showing that their compensation was inadequate and that they are entitled to a retroactive adjustment awarding them their "reasonable" costs in excess of the limits prescribed by the Secretary. We remand the Mt. Diablo case to the district court to permit Mt. Diablo to make the required showing.

We do not need to remand the Memorial case, however. The district court in that case did not decide that *Georgetown* overruled *Regents,* but rather concluded that Memorial had not made a factual showing sufficient to entitle it to relief under clause (ii) because it could not demonstrate that its costs were reasonable. Memorial did not challenge that finding before this court, except to argue that the fact that the Secretary subsequently changed the cost limits automatically rendered its costs reasonable. We reject this argument for the reasons already discussed. The fact that under *Regents* hospitals *may* be entitled to retroactive corrective adjustments does not absolve them of the responsibility of proving that they *are* entitled to such adjustments in any particular case.

IV

CONCLUSION

We conclude that the Secretary's method for calculating routine cost limits for Medicare reimbursement was not rendered arbitrary and capricious by the Secretary's failure to account for the use of part-time workers. We also conclude that hospitals are entitled to seek a retroactive adjustment to the wage index to account for the use of part-time workers. The decision of the district court in docket No. 90-15857, *Memorial Hospitals Ass'n v. Sullivan,* is AFFIRMED. The decision of the district court in docket No. 90-15772, *Mt. Diablo Hospital v. Sullivan,* is REVERSED and REMANDED.

42 U.S.C. § 1395x(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take

into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.